

IDAHO DEPARTMENT OF  
HEALTH & WELFARE

[simona@idhw.state.id.us](mailto:simona@idhw.state.id.us)  
**Division of Medicaid**  
**Reimbursement Unit**  
**P.O. Box 83720**  
**Boise, ID 83720-0036**  
**PHONE: 208-364-1994**  
**FAX: 208-334-2465**

**Note: The value of the unused medication returned from each prescription must equal \$15.00 or more.**

[illegible]

### \* Required Information

Returned Drug Fee Request Form

* Idaho Participant Medicaid ID # (MID)	* NDC #	* RX #	* Dispensing Date	* Billing Date	* Original Quantity	* New Quantity	Original Amount Paid	New Amount Paid	Paid Difference	√ IF FEE IS PAID
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